87-443

No.

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In the Supreme Court of the United States

OCTOBER TERM, 1987

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

ADAMS HOUSE HEALTH CARE, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

LAWRENCE G. WALLACE
Acting Solicitor General
Department of Justice
Washington, D.C. 20530
(202) 633-2217

58 pp

QUESTION PRESENTED

Whether the Provider Reimbursement Review Board may consider a health care provider's claim that it is entitled to reimbursement under the Medicare statute for a particular cost when the provider failed to seek reimbursement for that cost from its fiscal intermediary and did not otherwise reserve before the intermediary its right to seek reimbursement for that cost.

PARTIES TO THE PROCEEDING

In addition to the respondent named in the caption, the following were plaintiffs in the district court and are respondents in this Court: Adrian-Hillhaven Convalescent Center; Alta Vista Healthcare; Alvarado Convalescent and Rehabilitation Hospital; Anaheim-Hillhaven Convalescent Center; Andrew House Health Care; Asheville-Hillhaven Rehabilitation and Convalescent Center; Bancroft House Health Care; Beverly West Convalescent Hospital; Birchwood Terrace Health Care; Birmingham-Hillhaven Convalescent Center; Blueberry Hill Health Care; Boca Raton Convalescent Center; Burlingame-Hillhaven Convalescent Center; Claremont-Hillhaven Convalescent Hospital; Clayton House Health Care; Colonial Manor Nursing and Convalescent Home; Crest Knoll Health Care; Dirksen House Health Care; Dover House Health Care; East Manor Medical Care Center; El Paso-Hillhaven Convalescent Center; Embassy House Health Care; Fifth Avenue Convalescent Hospital; Garfield Convalescent Hospital; Great Barrington Health Care; Greenbriar Terrace Health Care; Hamilton Pavilion Health Care; Hanford-Hillhaven Convalescent Center; Hanover Terrace Health Care; Hemet-Hillhaven Convalescent Center; Hillhaven-Corpus Christi; Hillhaven-Highland House; Hillhaven-Lasalle Nursing Center; Hillhaven-Lawton Convalescent Hospital; Hillhaven-Omaha; Hillhaven-Orange Nursing Center; Hillhaven-Sherwood Convalescent Hospital; Hillhaven-Sunnybrook Convalescent Center; Knollwood Hall; Las Vegas Convalescent Center; Las Vegas-Hillhaven Convalescent Center; Louisville-Hillhaven Convalescent Center; Madison-Hillhaven Convalescent Center; Marietta-Hillhaven Convalescent Center; Maywood Acres Healthcare; Medicenter-Oklahoma City; Medicenter-Virginia Beach; Menlo Park-Hillhaven Convalescent Center; Mill Valley-Hillhaven Convalescent Center;

Mobile-Hillhaven Convalescent Center; Mountain Towers Health Care; Mountain View Health Care; Nineteenth Avenue-Hillhaven Convalescent Center; Norfolk-Hillhaven Rehabilitation Center and Convalescent Center; Ojai Manor Convalescent Hospital; Palo Alto-Hillhaven Convalescent Center; Pine Towers Convalescent Hospital; Raleigh-Hillhaven Convalescent Center; Reno Convalescent Center; River Terrace Health Care; Sacramento-Hillhaven Convalescent Center; Salt Lake City-Hillhaven Convalescent Center; San Francisco Convalescent Center; San Rafael-Hillhaven Convalescent Center; Santa Ana-Hillhaven Convalescent Center; Santa Cruz-Hillhaven Extended Care; Santa Paula Healthcare; Sarasota-Hillhaven Convalescent Center; Savannah Convalescent Center; Savannah-Hillhaven Convalescent Center; Saylor Lane Convalescent Hospital; Shorewood-Hillhaven Convalescent Center; Silverado Convalescent Hospital; Terrace Villa Convalescent Center; Twin Pines Health-Care; Valley House Health Care; Vancouver-Hillhaven Convalescent Center; Victorian Convalescent Hospital; Walden House Health Care; Wilmington-Hillhaven Convalescent Center; Winston-Salem Convalescent Center; Hillhaven Corporation; Board of Trustees of the Leland Stanford Junior University; Stanford University Hospital.

TABLE OF CONTENTS

	Page
Opinions below	1
Jurisdiction	1
Statutes involved	2
Statement	2
Reasons for granting the petition	6
Conclusion	7
Appendix A	1a
Appendix B	16a
Appendix C	31a
Appendix D	33a
Appendix E	35a
Appendix F	39a
Appendix G	41a

TABLE OF AUTHORITIES

Cases:

Athens Community Hospital, Inc. v. *Schweiker*, 743 F.2d 1 (D.C. Cir. 1984)	2-3

Statutes and regulations:

42 U.S.C. 1395c	2
42 U.S.C. (& Supp. III) 1395f(a)	2
42 U.S.C. (& Supp. III) 1395f(b)	2
42 U.S.C. (& Supp. III) 1395g	2
42 U.S.C. (& Supp. III) 1395h	3
42 U.S.C. (& Supp. III) 1395*oo*(a)(1)	3, 41a-42a
42 U.S.C. (& Supp. III) 1395*oo*(a)(2)	3, 42a
42 U.S.C. (& Supp. III) 1395*oo*(a)(3)	3, 42a
42 U.S.C. 1395*oo*(d)	3, 6, 42a
42 U.S.C. (& Supp. III) 1395*oo*(f)(1)	4, 42a-44a
42 U.S.C. (& Supp. III) 1395x(u)	2
42 U.S.C. (& Supp. III) 1395x(v)(1)(A)	2

Regulations – Continued: Page

42 C.F.R.:
Pt. 405:
Section 405.1803 3
Section 405.1803(c) 3
Section 405.1835 3
Section 405.1842 4
Section 405.1875 4
Section 405.1877 4
Section 405.1885 4
Pt. 413:
Section 413.20(a) 2
Section 413.20(b) 2
Section 413.24(f) 2
Section 413.24(f)(2) 2
Section 413.60 ..... 2, 3
Pt. 421:
Section 421.3 3
Sections 421.100-421.128 3

In the Supreme Court of the United States

OCTOBER TERM, 1987

No.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

ADAMS HOUSE HEALTH CARE, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in these consolidated cases.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-15a) is reported at 817 F.2d 587. One of the opinions of the district court (App., *infra*, 16a-30a) is reported at 604 F. Supp. 110. The other opinion of the district court (App., *infra*, 31a-32a) is unreported. The opinions of the Provider Reimbursement Review Board (App., *infra*, 35a-38a, 39a-40a) are unreported.

JURISDICTION

The judgment of the court of appeals (App., *infra*, 33a-34a) was entered on May 18, 1987. On August 12,

1987, Justice O'Connor extended the time for filing a petition for a writ of certiorari to and including September 15, 1987. The jurisdiction of this Court rests upon 28 U.S.C. 1254(1).

STATUTES INVOLVED

The relevant provisions of the Medicare statute are set forth at pages 41a-44a of the appendix to this petition.

STATEMENT

1. At the time of the events at issue in this case, all "providers" of health care services to Medicare beneficiaries were reimbursed by the Secretary of Health and Human Services on an annual basis for the "reasonable cost" of those health care services. 42 U.S.C. (& Supp. III) 1395f(b), 1395x(u), and (v)(1)(A).[1] Over the course of the year, the Secretary made payments to a provider based upon an estimate of the amounts owed to the provider. 42 U.S.C. (& Supp. III) 1395g; 42 C.F.R. 413.60. At the end of the year, the provider submitted a claim for reimbursement in the form of a "cost report." See 42 U.S.C. (& Supp. III) 1395f(a); 42 C.F.R. 413.20(a) and (b), 413.24(f).[2] The cost report is "a lengthy document consisting of numerous schedules, worksheets, and supplemental worksheets. * * * [A] cost report, when completed, is approximately three-quarters of an inch thick" (*Athens*

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[1] These cases concern payments under "Part A" of the Medicare statute, which provides coverage for "the costs of hospital, related post-hospital, home health services, and hospice care" (42 U.S.C. 1395c).

[2] The report is due three months after the end of the provider's fiscal year. The provider may obtain a 30-day extension of the due date for "good cause." 42 C.F.R 413.24(f)(2).

Community Hospital, Inc. v. *Schweiker*, 743 F.2d 1, 3 (D.C. Cir. 1984)). Providers list on the worksheets cost items for which they do not seek reimbursement because those cost items supply background information that supports the provider's cost claims.

The cost report is submitted to the provider's "fiscal intermediary" for review.[3] The intermediary audits the cost report and issues a Notice of Program Reimbursement specifying the total amount of reimbursement due to the provider and explaining any adjustments to the costs claimed by the provider. See 42 C.F.R. 405.1803.[4]

If a provider has timely filed its cost report and is "dissatisfied with [the intermediary's] final determination * * * as to the amount of total program reimbursement due the provider" or has not received a final determination on a "timely basis," the provider "may obtain a hearing with respect to such cost report" before the Provider Reimbursement Review Board (PRRB). 42 U.S.C. (& Supp. III) 1395*oo*(a)(1); see also 42 C.F.R. 405.1835.[5] The PRRB is authorized by statute (42 U.S.C. 1395*oo*(d)) to

> affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered

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[3] The intermediary, which is generally a private insurance company, is an entity that, pursuant to a contract with the Secretary, acts as the Secretary's agent in reviewing the provider's claims and determining the amount of reimbursement owed to the provider. See 42 U.S.C. (& Supp. III) 1395h; 42 C.F.R. 421.3, 421.100-421.128.

[4] The reimbursement award specified in the Notice of Program Reimbursement is compared to the Secretary's payments to the provider. Any deficiency is paid by the Secretary and any overpayment is repaid by the provider. 42 C.F.R. 405.1803(c), 413.60.

[5] Review by the PRRB is available only if the amount in controversy is $10,000 or more and the provider's request for a hearing is timely filed (42 U.S.C. (& Supp. III) 1395*oo*(a)(2) and (3)).

> by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Board's decision is final unless the Secretary reverses, affirms, or modifies the decision within 60 days. The Board's decision—or the Secretary's modified decision, if any—is subject to judicial review in federal district court pursuant to the Administrative Procedure Act. 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); 42 C.F.R. 405.1875, 405.1877.

The statute establishes a second, more expeditious route into court in certain circumstances. A provider may obtain direct judicial review of "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines * * * that it is without authority to decide the question." 42 U.S.C. (& Supp. III) 1395*oo*(f)(1); see also 42 C.F.R. 405.1842.[6]

2. This case involves two separate sets of respondents, all of which are certified as providers of health services under the Medicare program. The first group of respondents is composed of 76 skilled nursing facilities.[7] During the course of their fiscal year ending in May 1981, these respondents invested certain funds in interest-bearing instruments for more than six months. Pursuant to the applicable Medicare standards, respondents listed these funds in their cost reports, but excluded the funds in computing the allowable return on equity in their 1981 cost reports. Respondents thus "self-disallowed" their claim

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[6] A final decision may be reopened by the intermediary, the Board, or the Secretary in certain circumstances. See 42 C.F.R. 405.1885.

[7] Eighty-two facilities were involved in the administrative phase of the litigation, but six facilities did not seek review of the administrative determination that their claims were not ripe because the intermediary had not yet issued Notices of Program Reimbursement. App., *infra*, 20a n.1.

that these funds should be included in calculating their entitlement to return on capital. After the intermediary's issuance of the Notices of Program Reimbursement, respondents sought to amend their cost reports to include these funds in the return on capital computation; the intermediary did not allow the amendment. App., *infra*, 3a, 19a-20a.

Respondents then filed an appeal before the Provider Reimbursement Review Board raising the claim that the funds should have been included in calculating return on capital; the Board concluded that it lacked jurisdiction over the claim (App., *infra*, 35a-38a). The Board observed that "the costs were not claimed in the various Providers' cost reports; nor have any amended cost reports been accepted by the Intermediary on this issue; nor have any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue" (*id.* at 36a-37a). The Board stated that as a prerequisite to Board jurisdiction a provider must "claim a cost in a filed cost report or, at least, disclose its position on the issue so the Intermediary can make a final determination" (*id.* at 37a).

The second group of respondents operate Stanford University Hospital. In its 1981 cost report, the hospital calculated its claim for reimbursement for Medicare services by "using the 'average cost per diem' method set forth in the Medicare Provider Reimbursement Manual" (App., *infra*, 4a). The intermediary issued a Notice of Program Reimbursement and the hospital filed an appeal with the Board, claiming that the manual improperly required inclusion of labor and delivery room patient days in calculating per diem reimbursement. The Board declined to review the issue on the ground that it lacked jurisdiction over claims that were not expressly disclosed to the intermediary in the cost report. *Id.* at 4a, 39a-40a.

Respondents sought judicial review in two separate actions filed in the United States District Court for the Northern District of California; the court reversed the Board's determination in both cases. See App., *infra*, 16a-30a, 31a-32a. It stated that "an item is 'covered by' the cost report within the meaning of 42 U.S.C. § 1395oo(d) if a 'self-disallowance' of the cost is reported in the cost report," and concluded that "the Board has jurisdiction to review disputes regarding such disallowed costs." *Id.* at 30a; see also *id.* at 31a-32a.[8]

3. The court of appeals upheld the district court's determinations (App., *infra*, 1a-15a). The court relied upon the plain language of Section 1395*oo*(d), observing that the provision authorizes the Board to review "even matters 'not considered by the intermediary.' " App., *infra*, 7a (quoting 42 U.S.C. 1395*oo*(d)). The court rejected the Secretary's contention that this interpretation of Section 1395*oo*(d) conflicts with other provisions of the Medicare statute and would lead to adverse practical consequences (see App., *infra*, 7a-14a). The court concluded that the statute "plainly requires the Board to consider matters included in a cost report and timely appealed, even if not expressly claimed before an intermediary" (*id.* at 14a-15a).

REASONS FOR GRANTING THE PETITION

The question presented in this case is the same as the question presented in *Bethesda Hospital Ass'n* v. *Bowen*, petition for cert. pending, No. 86-1764, *i.e.*, whether the Medicare statute requires a provider to raise a reimbursement claim before the intermediary in order to obtain further administrative or judicial review.[9] The court of

[8] On remand, the Board rejected respondents' claim relating to the invested capital on the merits. Respondents have sought judicial review of that determination before the United States District Court for the District of Columbia. See App., *infra*, 4a n.2.

[9] We have served respondents' counsel with a copy of our response to the petition in *Bethesda Hospital Ass'n*.

appeals in this case concluded that the jurisdiction of the Provider Reimbursement Review Board is not limited to matters put into dispute before the intermediary (see App., *infra*, 5a, 7a-14a). For the reasons stated in our response (at 7-11) to the petition for a writ of certiorari in *Bethesda Hospital Ass'n*, we believe that the court of appeals in that case correctly held that a provider must raise a reimbursement claim before its intermediary in order to obtain further review of that claim. The *Bethesda Hospital Ass'n* court's conclusion regarding the scope of the Board's jurisdiction is supported by the language and structure of the Medicare statute, and by significant practical considerations. Because of the conflict among the courts of appeals and the importance of the issue, however, we have suggested that the Court should grant the petition for a writ of certiorari in *Bethesda Hospital Ass'n*.

CONCLUSION

The petition for a writ of certiorari should be held and disposed of as appropriate in light of the disposition of *Bethesda Hospital Ass'n* v. *Bowen*, petition for cert. pending, No. 86-1764.

Respectfully submitted.

LAWRENCE G. WALLACE
*Acting Solicitor General**

SEPTEMBER 1987

*The Solicitor General is disqualified in this case.

APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

No. 85-1512
D.C. No. C-83-3020 WHO

ADAMS HOUSE HEALTH CARE, ADRIAN-HILLHAVEN CONVALESCENT CENTER; ALTA VISTA HEALTHCARE; ALVARADO CONVALESCENT AND REHABILITATION HOSPITAL; ANAHEIM-HILLHAVEN CONVALESCENT; ANDREW HOUSE HEALTH CARE; ASHEVILLE-HILLHAVEN REHABILITATION AND CONVALESCENT CENTER; BANCROFT HOUSE HEALTH CARE; BEVERLY WEST CONVALESCENT HOSPITAL; BIRCHWOOD TERRACE HEALTH CARE; BIRMINGHAM-HILLHAVEN CONVALESCENT CENTER; BLUEBERRY HILL HEALTH CARE; BOCA RATON CONVALESCENT CENTER, ET AL., PLAINTIFFS-APPELLEES

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

No. 86-1872
D.C. No. CV-85-3370-WHO

BOARD OF TRUSTEES OF THE LELAND STANFORD JUNIOR UNIVERSITY; STANFORD UNIVERSITY HOSPITAL, PLAINTIFFS-APPELLEES

v.

OTIS R. BOWEN, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANT-APPELLANT

On Appeal from the United States District Court
for the Northern District of California
William H. Orrick, Jr., District Judge, Presiding

Argued and Submitted:
December 12, 1986—San Francisco, California

Filed: May 18, 1987

OPINION

Before: William A. Norris, Robert R. Beezer and Melvin Brunetti, Circuit Judges.

BEEZER, Circuit Judge:

The parties present an unsettled question of statutory construction: may a Medicare provider claim certain costs in a proceeding before the Provider Reimbursement Review Board when the provider included but failed to claim such costs in its annual Medicare cost report? In these consolidated cases, the Board held it had no power to consider reimbursement items not expressly claimed by the providers in their cost reports. The district court remanded both cases, directing the Board to accept jurisdiction over disputes concerning such reimbursement items. We have jurisdiction pursuant to 28 U.S.C. § 1291 and we affirm.

I

BACKGROUND

A. The Medicare Program

The Medicare program is set forth in subchapter XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* (1982). Part A of the program, under which these cases arise,

authorizes federal reimbursement for hospital care provided to the elderly and disabled. 42 U.S.C. § 1395c-1395i-2. Until recently, a health care "provider" (*e.g.*, a hospital) submitted annual cost reports to a "fiscal intermediary" (usually a private insurance company) for review; the fiscal intermediary acted as an agent of the Secretary of Health and Human Services. The intermediary audited the cost report and issued a Notice of Program Reimbursement with an explanation of any audit adjustments or disallowed costs.[1] If the provider was not satisfied, the statute provided an avenue of administrative appeal to the Provider Reimbursement Review Board ("Board") which, since it is central to this case, will be set forth at length below.

B. *Adams House,* No. 85-1512

The appellants, 82 skilled nursing facilities under common ownership, will be referred to collectively as "Adams House." In fiscal year 1981, Adams House claimed an allowance for a "reasonable return on equity capital invested and used in the provision of patient care," pursuant to 42 C.F.R. § 405.429(a)(1)(i) (1983). Following the rules set forth in the Medicare Provider Reimbursement Manual, however, Adams House made no claim relative to assets invested for more than six months, though such assets were listed in the cost report. Later, claiming that the Manual conflicted with the regulations, Adams House filed an appeal with the Board seeking an allowance for these investments. The Board declined review on the ground that it lacked power to consider claims not expressly disclosed to the intermediary in the cost report.

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[1] We note that the procedure for provider reimbursement was greatly changed in the Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65. Beginning in 1983, reimbursement for most providers is based no longer on provider costs, but on a fixed rate for each "Diagnosis Related Group."

Adams House appealed to the district court pursuant to 42 U.S.C. § 1395oo(f) and both parties moved for summary judgment. Summary judgment was entered in favor of Adams House on October 17, 1984. The case was remanded to the Board, which was ordered to accept jurisdiction. 604 F. Supp. 110, 117 (N.D. Cal. 1984).[2] The Secretary timely appealed.

C. *Board of Trustees of Stanford*, No. 86-1872

The appellant ("Stanford") owns and operates the Stanford University Hospital. In fiscal year 1981, Stanford claimed reimbursement for Medicare services rendered, using the "average cost per diem" method set forth in the Medicare Provider Reimbursement Manual. Later, claiming that the Manual's rules improperly required inclusion of labor and delivery room patient days in the per diem calculation, Stanford filed an appeal with the Board. The Board declined review on the ground that it lacked power to consider claims not expressly disclosed to the intermediary on the cost report.

Stanford appealed to the district court and both parties moved for summary judgment. Summary judgment was entered in favor of Stanford on January 29, 1986. The Secretary timely appealed and this case was consolidated with *Adams House* for argument.

II

ANALYSIS

We review the district court's grant of summary judgment *de novo*. *Vance v. Hegstrom*, 793 F.2d 1018, 1022

[2] The Board conducted a hearing and ruled against Adams House on the merits of its claim. Adams House appealed to a federal district court in the District of Columbia. That appeal has been stayed pending our decision.

(9th Cir. 1986). In other words, we review the Board's refusal to accept jurisdiction under the same standard as did the district court.

Judicial review of Medicare reimbursement decisions is governed by the Administrative Procedure Act, 5 U.S.C. §§ 701-06 (1982). *See* 42 U.S.C. § 1395oo(f)(1); *Western Medical Enterprises, Inc. v. Heckler*, 783 F.2d 1376, 1380 (9th Cir. 1986). According to that Act, the courts must set aside any agency action found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706. We defer to an agency when it fills gaps or resolves ambiguities in the statute it administers, but we must reject agency rules that thwart the expressed intent of Congress. *See Chevron U.S.A. Inc. v. Natural Resources Defense Council,* 467 U.S. 837, 842-45 (1984); *Regents of the University of California v. Heckler*, 771 F.2d 1182, 1187 (9th Cir. 1985).

The central question in this case is whether the Provider Reimbursement Review Board correctly decided that it had no power to consider reimbursement claims not expressly made to a fiscal intermediary in a cost report. Some federal courts have held that the Board's power is so limited; many of those decisions rely in large part on the thoughtful opinion in *Athens Community Hospital, Inc.* v. *Schweiker,* 743 F.2d 1 (D.C. Cir. 1984) ("*Athens II*"). *See University of Cincinnati v. Sec'y of Health and Human Services,* 809 F.2d 307 (6th Cir. 1987); *North Broward Hosp. Dist. v. Bowen,* 808 F.2d 1405 (11th Cir. 1987); *Baptist Hospital East v. Sec'y of Health and Human Services,* 802 F.2d 860 (6th Cir. 1986); *Community Hosp. of Roanoke Valley v. Health and Human Services,* 770 F.2d 1257 (4th Cir. 1985). Other federal courts, including the district court below, have disputed the Board's narrow view of its powers. *See St. Luke's Hospital v. Sec'y of Health and Human Services,* 810 F. 2d 325 (1st

Cir. 1987) ("*St. Luke's*"); *St. Mary of Nazareth Hospital Center v. Dep't of Health and Human Services*, 698 F.2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983) ("*St. Mary of Nazareth*"). After reviewing the statutory scheme we believe the Board does have the power and the obligation to hear the appeals of Adams House and Stanford.

The administrative appeals process for health providers is set forth in the following statutes.

42 U.S.C. § 1395oo(a):

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . .
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days. . . .

42 U.S.C. § 1395oo(d):

> A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though

such matters were not considered by the intermediary in making such final determination.

May the Board hear matters not previously raised before a fiscal intermediary? We note initially that the plain language of the statute appears to settle this question. According to section 1395oo(d), the Board may review even matters "not considered by the intermediary." This portion of the statute was considered decisive by the Seventh Circuit. *See St. Mary of Nazareth*, 698 F.2d at 1346. The D.C. Circuit disagreed, arguing that this plain language "does not comport with the statutory scheme, would have adverse practical consequences, and conflicts with the reopening regulations [42 C.F.R. § 405.1885 *et seq.* (1986)] as well as the agency's own interpretation of the statute." *Athens II*, 743 F.2d at 6. The Secretary, in accord with *Athen II*, argues in the present cases that, since the statutory scheme is puzzling or ambiguous, the agency's reasonable interpretation is entitled to deference even if it appears to conflict with one part of that scheme. As the following review of the *Athens II* arguments shows, however, none of the suggested ambiguities warrants departure from the plain language of the statute.

1. Alleged Conflict Within 42 U.S.C. § 1395oo(d)

The D.C. Circuit held that a literal reading of subsection (d), by which the Board has power to review matters not raised before the intermediary, "ignores and would make meaningless" another part of subsection (d), which limits the Board's power of review to "matters covered by [a] cost report." *Athens II*, 743 F.2d at 6. But it is no contradiction to say that a certain cost, though not explicitly raised before an intermediary, was covered by a cost report. The phrase "covered by a cost report" should be read broadly, in light of similar broad language elsewhere in the statute and regulations. *See* 42 U.S.C. § 1395oo(a)

(provider may obtain a hearing "with respect to" a cost report if he is dissatisfied with the intermediary's proposed reimbursement "for the period covered by such report"); *cf.* 42 C.F.R. § 405.453(f) (1983) (cost reports "generally cover a consecutive 12-month period of the provider's operations").

We believe that a cost is "covered by a cost report" if it was incurred within the period which is the subject of the report and is reflected in that report, even if it is not expressly claimed.[3] There is no conflict within subsection (d).

2. Alleged Conflict Between 42 U.S.C. § 1395oo(a) and (d)

The D.C. Circuit correctly held that subsections (a) and (d) must be read together. It then held that a literal reading of (d), by which the Board has the power to consider matters not claimed before an intermediary, would conflict with subsection (a), which requires that the provider must be "dissatisfied with a final determination" of its intermediary before being entitled to Board review. The Court's summary follows:

> It simply is not plausible to contend that Congress has created a scheme where the provider can claim dissatisfaction and have recourse to an appeal procedure because the intermediary failed to read the provider's mind and anticipate all those things the provider would like to be reimbursed for, even though it did not request them.

Athens II, 743 F.2d at 6 (footnote omitted).

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[3] We do not decide whether a cost incurred within a particular period but completely omitted from the relevant cost report may be said to be "covered by" that report. The First and Seventh Circuits have concluded that such completely omitted matters may be reviewed by the Board. *See St. Luke's*, 810 F.2d at 327-28; *St. Mary of Nazareth*, 698 F.2d at 1346.

We understand this argument, but we do not agree. It is perfectly plausible, and apparently agreed by the parties, that in these cases, the providers submitted cost reports, the intermediaries made final determinations concerning them,[4] and the providers were dissatisfied with the total reimbursement offered. Section (a) requires that a provider be dissatisfied with the total amount of reimbursement offered by an intermediary, not with the intermediary's reasoning process with respect to any specific costs. Moreover, the providers' failure to claim certain costs at the intermediary level reflects no *fault* or *neglect* on them (contrary to the suggestion of the *Athens II* court); it reflects the fact that any such claim would have been pointless. The intermediary has no authority to deviate from the Medicare Provider Reimbursement Manual. As soon as the providers were before the Board, they made their dissatisfaction regarding specific reimbursement policies known. The language of subsection (a) requires no more, and it does not conflict with subsection (d).

3. Alleged Adverse Practical Consequences

The D.C. Circuit identified three closely related adverse consequences that it feared would result if the Board could review cost items not claimed before an intermediary. First,

> a provider could list every conceivable cost on its cost report, without claiming reimbursement, and hope that the intermediary will reimburse it for the reported but unclaimed costs, secure that it never-

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[4] According to 42 C.F.R. § 405.1801(a) (1986), a final determination is an intermediary's decision concerning the total reimbursement due a provider for a particular period, as embodied in the Notice of Program Reimbursement.

> theless will have until 180 days following the [final determination] to concoct some reasons to urge upon the [Board] for reimbursement. . . .

Athens II, 743 F.2d at 6.

We do not believe that our interpretation of the statute encourages frivolous padding of cost reports any more than the *Athens II* interpretation encourages frivolous cost claims. If providers are prepared to list "every conceivable cost" on their cost reports, there is nothing to stop them from overtly disclosing and claiming those costs in the manner mandated by the *Athens II* court. In *both* cases, abuses are contained by the antifraud provisions of 42 U.S.C. § 1395nn. There is no evidence in the record that abuses have occurred.

The second adverse consequence asserted is that our interpretation would "deprive [the Board] of the intermediary's analysis and conclusions and make the [Board] the tribunal of original jurisdiction, eliminating a tier of review." *Athens II* at 6-7 (quoting *Athens Community Hospital, Inc. v. Schweiker,* 686 F.2d 989, 997 (D.C. Cir. 1982) ("*Athens I*")). We believe that this consequence is not always adverse. As remarked earlier, in the present cases it would have been pointless to present the providers' claims to the intermediaries, which had no power to grant relief. There is no reason to think, in these cases, that the intermediaries' "analysis and conclusions" would have helped the Board.[5] Moreover, it appears that Congress deliberately set up the Board's review procedure as a " 'hybrid,' exhibiting some features of initial factfinding (witnesses, cross-examination, new evidence) and some features of review." *St. Luke*'s, 810 F.2d at 328.

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[5] By contrast, in areas within the intermediaries' competence the providers would have an incentive to present their claims directly to the intermediaries.

The third apprehended consequence is that our interpretation would

> render virtually meaningless the time limits for the filing of cost reports established by [42 C.F.R. § 405.453(f)(2) (1983)]. Instead of being required to file within three months, with a maximum extension of 30 days, the provider could file new cost claims for as long as its appeal as to any claim was pending before the [Board].

Athens II, 743 F.2d at 7 (quoting *Athens I*, 686 F.2d at 997).

We note that this consequence arises only if the Board is allowed to review matters totally omitted from a cost report. We have expressly left this issue open (see note 3, *supra*). Even if the Board's review were extended to matters omitted from a cost report, however, the three month filing regulation would not be "meaningless." It would still require a cost report to be filed within three months of the end of the reporting period. If no report were filed, the provider would have no relief. *See Athens I*, 686 F.2d at 994 & n.7.

4. Alleged Conflict With Reopening Regulations

This argument is best understood by reference to the factual background of *Athens I* and *Athens II*. *See Athens I*. 686 F.2d at 991-92. In that case, a provider filed a timely cost report but completely omitted certain costs, apparently by inadvertence. The intermediary issued a final determination concerning the listed costs and the provider appealed to the Board. While this appeal was pending, the provider petitioned the intermediary to amend its cost report, pursuant to the reopening regulations, 42 C.F.R.

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[5] By contrast, in areas within the intermediaries' competence the providers would have an incentive to present their claims directly to the intermediaries.

§ 405.1885 *et seq.* When this petition was denied, the provider attempted to litigate its entitlement to the unlisted costs before the Board, by adding those issues to its pending appeal. In that circumstance, the D.C. Circuit concluded that allowing the Board to hear the new claims would "eviscerate the finality provision" of 42 C.F.R. § 405.1885(c), which it interpreted as making an intermediary's decision not to reopen immune from appeal. *See Athens II,* 743 F.2d at 7.

We note that this argument has force only if the Board is allowed to review matters completely omitted from a cost report. We have expressly left this issue open (*see* note 3, *supra*). Even if the Board's review were extended to matters omitted from a cost report, however, the finality provision of 42 C.F.R. § 405.1885(c) would not be eviscerated.[6] Appeal to the Board does not force an intermediary to reopen its deliberations against its will. There is finality at the intermediary level. The D.C. Circuit's idea that this finality should extend to the Board stems from the notion, which we have rejected above, that the Board exercises purely a power of review with no element of initial jurisdiction.

5. Conflict With The Board's Interpretation

The D.C. Circuit noted that its interpretation of the statute agreed with the Board's interpretation, citing several Board opinions. *See Athens II,* 743 F.2d at 8. The Secretary argues here that because the statutory language is at least ambiguous, the Board's interpretation of the statute is entitled to substantial deference by this court.

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[6] We assume *arguendo* that the D.C. Circuit analyzed this section of the regulations correctly, though this could be debated. *See Kootenai Hospitai Dist. v. Bowen,* 650 F. Supp. 1513, 1520 (N.D. Cal. 1987). We agree with the D.C. Circuit that in any case the regulations are "not dispositive" of the proper interpretation of the statute. *Athens II,* 743 F.2d at 8.

See Chevron U.S.A. Inc. v. Natural Resources Defense Council, 467 U.S. 837, 842-43 (1984). However, assuming *arguendo* that the statute is ambiguous, the Secretary's reliance on *Chevron* is misplaced for three reasons. First, the Supreme Court recently explained that *Chevron's* rule of deference to agency interpretations is applicable only in situations where "the agency is required to apply [legal] standards to a particular set of facts." *INS v. Cardoza-Fonseca,* 107 S. Ct. 1207, 1221 (1987). Interpretation of the Board's jurisdiction requires no such application of an accepted legal standard to specific facts; rather, it requires interpretation of a contested legal standard and therefore "is a pure question of statutory construction for the courts to decide." *Id.* Second, the Board has not consistently adhered to a single interpretation of its jurisdictional authority, as it sometimes has reviewed matters not presented to an intermediary. *See St. Luke's,* 810 F.2d at 330 and cases cited there. In *Cardoza-Fonseca* the Supreme Court declared that "the inconsistency of the positions [an agency] has taken through the years" is grounds for "rejecting the Government's request for heightened deference to its position." 107 S. Ct. at 1221 n.30. Finally, deference to an agency's interpretation of the statutory scheme it is designed to administer is not warranted when the "construction requires consideration of broad concerns beyond the agency's expertise." *Grunfeder v. Heckler,* 748 F.2d 503, 505 (9th Cir. 1984) (en banc). While the Board may enjoy special expertise in interpreting and applying the substantive provisions of the Medicare statutory scheme, unlike courts it has no special expertise at interpreting provisions governing jurisdiction. Hence, even if we agreed with the Secretary that the statutory language was ambiguous (which we do not), we would still be bound to embrace the most plausible interpretation of the jurisdictional provision without deferring to the Board's preferred construction. Along with the First

and Seventh Circuits we read the statute and regulations to allow the Board to consider matters included in a cost report but not expressly claimed before an intermediary.

One question remains: *must* the Board consider all matters timely raised before it? The First Circuit held that the Board had discretion to hear appeals or not, relying on language in 42 U.S.C. § 1395oo(d) providing that the Board "shall have the power" to do certain things. *See St. Luke's,* 810 F.2d at 327-28. We disagree. The discretionary language does not describe the Board's power to accept or reject appeals. It describes the Board's options once an appeal is filed. More fully quoted, section (a) provides that the Board "shall have the power to affirm, modify, or reverse a final determination. . . and to make any other revisions . . . ." The Board has no discretion to reject an appeal, for as 42 U.S.C. § 1395oo(a) provides,

> Any provider of services which has filed a required cost report within the time specified in regulations *may obtain a hearing* with respect to such cost report by a Provider Reimbursement Review Board . . . . (emphasis added)

The word "may" in the emphasized language connotes not contingency but entitlement. *Cf. Goodman v. City Products Corp.,* 425 F.2d 702, 703 (6th Cir. 1970) (the phrase "a civil action may . . . be brought" refers to "the option of the aggrieved party to bring a lawsuit, not to a discretion in the Court. . . .").

III

CONCLUSION

Our review of the *Athens II* rationale convinces us that the Medicare statute is not puzzling or ambiguous, despite the Secretary's claims. On the contrary, it plainly requires

the Board to consider matters included in a cost report and timely appealed, even if not expressly claimed before an intermediary.

In the *Adams House* case, the appellants listed the assets held for over six months in their cost report and included a claim for "reasonable return" in their timely appeal to the Board. The district court ordered the Board to consider this issue. That decision is AFFIRMED.

In the *Stanford* case, the appellant included information in its cost report concerning labor and delivery room patient days and included a claim for recalculation of its "average cost per diem" in its timely appeal. The district court ordered the Board to consider this issue. That decision is AFFIRMED.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

Civil No. C-83-3020 WHO

ADAMS HOUSE HEALTH CARE, ET AL., PLAINTIFFS

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS

Aug. 10, 1984

OPINION AND ORDER

ORRICK, District Judge.

This case, before the Court on cross-motions for summary judgment, concerns the statutory and regulatory scheme of the Medicare Act by which the government reimburses those who provide health care to Medicare recipients. The Court is asked to interpret the statute and regulations that allow a provider of services to obtain review by the Secretary of Health and Human Services ("the Secretary") of the amounts reimbursed to it.

In an opinion filed April 2, 1984, the Court granted the Secretary's motion for summary judgment and denied plaintiffs' motion. Plaintiffs then moved for reconsideration, contending that the Court based its decision on a mistaken apprehension of a fact crucial to the outcome of the case. Oral argument on the motion for reconsideration was heard on June 8, 1984. For the reasons following, the Court now grants the motion for reconsideration and also grants plaintiffs' motion for summary judgment; the Court vacates its earlier decision in favor of the Secretary and denies her motion for summary judgment.

I

A

Title XVIII of the Social Security Act, popularly known as the Medicare Act, 42 U.S.C. § 1395 *et seq.*, establishes a federally funded health insurance program that provides medical care to the aged and disabled. Skilled nursing facilities, such as plaintiffs in this case, participate in the program by entering into "provider agreements" with the Secretary, under which the facilities furnish services to Medicare beneficiaries. 42 U.S.C. § 1395x(j). Such facilities are referred to as "providers" in the statute and pertinent regulations. Pursuant to those agreements, the Secretary reimburses providers for the reasonable cost of caring for Medicare recipients. 42 U.S.C. §§ 1395f(b), 1395x(v); 42 C.F.R. §§ 405.401 *et seq.* The provider appoints a "fiscal intermediary," usually a private insurance company, that acts as the Secretary's agent for the purpose of reviewing and awarding reimbursement claims. 42 U.S.C. § 1395h. Providers are reimbursed at least monthly, subject to later adjustment. 42 C.F.R. § 405.405. At the end of the provider's fiscal year, it submits a cost report to the intermediary. 42 C.F.R. § 405.406. The intermediary then determines the actual amount of reimbursement to which the provider is entitled and issues a "notice of program reimbursement," or "NPR." If the actual reimbursable amount differs from the amount already paid for that period, an appropriate adjustment is made in later payments to recoup or repay the discrepancy. *Id.*

In general, when a provider is dissatisfied with the intermediary's final reimbursement decision and the amount in controversy is $10,000 or more, the provider may within 180 days of the receipt of the NPR request a hearing "with respect to such report" before the Provider Reimbursement Review Board ("the Board"). 42 U.S.C. § 1395oo(a).

Alternatively, a group of providers, each of whom would individually be entitled to a hearing under § 1395oo(a), may request a group appeal if the matters in controversy in their cost reports involve a common question of fact or interpretation of the statute or regulations, and if the total amount in controversy is $50,000 or more. 42 U.S.C. § 1395oo(b).

The Board, a statutorily created body within the Department of Health and Human Services, may affirm, modify, or reverse reviewable reimbursement decisions of the fiscal intermediary. 42 U.S.C. § 1395oo. Within sixty days after a final decision of the Board, the Secretary may review the Board's decision on her own motion or on motion by the provider. 42 U.S.C. § 1395oo(f); 42 C.F.R. § 405.1875. The provider may also obtain judicial review of a final decision by the Board or the Secretary, by filing a civil action within 60 days of the date of such a final decision. *Id.*

B.

Congress authorized the Secretary to promulgate regulations governing what costs incurred by the provider are reimbursable. *See* 42 U.S.C. §§ 1395hh, 1395x(v). The underlying dispute in this case, which is not before the Court, concerns plaintiffs' right to reimbursement pursuant to 42 C.F.R. § 405.429(a)(1)(i). That regulation provides:

> "A reasonable return on equity capital invested and used in the provision of patient care is paid [to the provider] as an allowance in addition to the reasonable cost of covered services furnished to beneficiaries by proprietary providers."

This provision is in apparent conflict with the Medicare Provider Reimbursement Manual, which requires the provider to exclude from the computation of return on equity

capital funds remaining in investment status for more than six months. Prov.Reim. Manual, Part I, § 1218.2. Further, in computing reasonable cost of services provided, otherwise allowable interest expenses must be reduced by the income from invested funds. 42 C.F.R. § 405.419(b)(2)(iii). Thus, the reimbursement authorized by 42 C.F.R. § 405.429 is significantly reduced by the exclusions required in the Provider Reimbursement Manual, Part I, § 1218.2, and 42 C.F.R. § 405.419(b)(2)(iii).

C.

Plaintiffs in this case are eighty-two skilled nursing facilities owned by Hillhaven Corporation. Certain administrative and management functions are carried out on behalf of plaintiffs through the Hillhaven home office. The costs incurred by the home office are reimbursed by the medicare program to plaintiffs using allocation methods prescribed in Medicare regulations and instructions. Plaintiffs' costs of providing services to Medicare beneficiaries are determined based on cost reports for each plaintiff and the Hillhaven Corporation home office, which are submitted on an annual basis. See Affidavit of R.L. Kearney, Reimbursement Manager for Hillhaven Corporation.

During the corporation's fiscal year ending May 31, 1981, plaintiffs, through the Hillhaven home office, had funds invested for more than six months in certificates of deposit, treasury bills, and similar notes. Plaintiffs filed their 1981 cost reports, complying with the rules governing the offset of interest income against allowable interest expense, and the exclusion of invested funds held for more than six months from the computation of return on equity capital. Plaintiffs did not object to the application of those rules to their cost reports at the time of filing. The

fiscal intermediary issued NPRs to seventy-six of the plaintiffs between February 16, 1982 and June 18, 1982.[1]

On March 26, 1982, plaintiffs requested the intermediary's permission to amend their 1981 cost reports to include invested funds held longer than six months in the computation of the return on equity capital. The intermediary did not allow the amendment.

Plaintiffs then filed a group appeal before the Board requesting a hearing on the validity of the simultaneous application of the Medicare rules discussed above, claiming that the simultaneous application of those provisions results in undercompensation of plaintiffs for the reasonable cost of providing medical services to Medicare beneficiaries as required by the Medicare statute and regulations. *See* 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 405.401 *et seq.*

On April 19, 1983 the Board declined to review plaintiffs' claim. The Board held that the providers had not met the jurisdictional requirement for review because they had not claimed the disputed amounts in their cost reports. The Board stated that its jurisdiction depended on the provider having made an overt disclosure to the intermediary of its posture on a particular issue, which ordinarily would be evidenced by claiming reimbursement for the item in the cost report. *See* Administrative Record, 5-7. Plaintiffs argued unsuccessfully that claiming reimbursement for the disputed amounts would have put them in violation of the Medicare regulations.

Plaintiffs next requested that the Administrator of the Health Care Financing Administration, on behalf of the

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[1] Six members of the Hillhaven Group had not received NPRs before plaintiffs sought PRRB review. As to those six, the Board declined to review their cost reports because receipt of an NPR is a jurisdictional prerequisite to Board review. The correctness of that decision has not been challenged.

Secretary, reverse the Board's decision. On June 2, 1983, the Administrator declined to review the case. The Board decision thus became the final decision of the Secretary and is now before this Court for review.

II

This Court's jurisdiction over this case is based on 42 U.S.C. § 1395oo(f)(1) of the Medicare Act, which provides in pertinent part:

> "Providers shall have the right to obtain judicial review of any *final decision* of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action * * *. * * * Such actions shall be brought in the district court of the United States for the judicial district in which the provider is located * * *."

(Emphasis added.)

A Board decision not to exercise jurisdiction is a "final decision" under § 1395oo(f)(1). *Athens Community Hospital Inc. v. Schweiker,* 686 F.2d 989, 993-94 (D.C.Cir. 1982), *citing Cleveland Memorial Hospital, Inc. v. Califano,* 444 F.Supp. 125 (E.D.N.C.1978), *aff'd,* 594 F.2d 993 (4th Cir. 1979). Although the parties in this case have not raised the issue, the Court notes that if a refusal by the Board to exercise jurisdiction were not reviewable, "the [Board] could effectively preclude any judicial review of its decisions simply by denying jurisdiction of those claims that it deems to be non-meritorious." *Cleveland,* 444 F.Supp. at 128. The *Cleveland* court analogized the jurisdictional question to 28 U.S.C. § 1291, which grants courts of appeal the power to review "final decisions" of the district courts. Under that statute, dismissals for lack of jurisdiction have consistently been understood as "final" and hence, reviewable, decisions. *See, e.g., W.E. Hedger Transportation Corp. v. Ira S. Bushey & Sons,* 115

F.2d 321 (2d Cir.). *cert. denied,* 329 U.S. 735, 67 S.Ct. 100, 91 L.Ed. 635 (1946).

This Court finds the jurisdictional rationale in *Athens* and *Cleveland* persuasive. Because the Board's refusal to exercise jurisdiction over plaintiffs' claims is a final decision pursuant to 42 U.S.C. § 1395oo(f)(1), this Court has jurisdiction to entertain plaintiffs' appeal of the Board's refusal to review their claims.

III

A

The precise issue before this Court is whether the Board properly refused to review the fiscal intermediary's determination of the reimbursements due plaintiffs for the 1981 fiscal year. In other words, did the Board lack jurisdiction to hear plaintiffs' appeal from the intermediary's decision?

The statute granting the Board jurisdiction to hear appeals from final decisions of the fiscal intermediary is 42 U.S.C. § 1395oo(d), which provides as follows:

> "The Board shall have the power to affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination."

It is clear from the statute that the Board's jurisdiction turns on whether a matter was "covered" by a cost report. *See generally Athens Community Hospital, supra,* 686 F.2d at 997 (D.C.Cir. 1982).

In this case the Secretary takes the position that an item is "covered by the cost report" within the meaning of 42 U.S.C. § 1395oo(d) only if the provider has affirmatively

claimed it for reimbursement. Plaintiffs are not entitled to Board review, the Secretary insists, because they "self-disallowed" these items, rather than claiming reimbursement for them.

B

By "self-disallowance" a provider recognizes that an incurred cost is not reimbursable under the Medicare regulations. A provider could either not record the self-disallowance amount on the cost report, or could record the expenditure and then subtract it out of the claim for reimbursement. Plaintiffs chose the latter method.

Hillhaven Corporation, the home office for the individual plaintiffs in this case, submitted to the fiscal intermediary a "home office" cost report that recorded *all* home office costs, including an amount for reasonable return on equity capital invested and used in the provision of patient care. Adjustments were then made to the total equity capital cost by offsetting investment income against allowable interest expense and by excluding the funds invested for more than six months. These exclusions, or disallowances, were recorded on the cost report. *See* Affidavit of R.L. Kearney and exhibits thereto.[2]

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[2] Mr. Kearney's affidavit states:

> In preparing the Medicare cost reports for plaintiffs and the Hillhaven Corporation home office for the fiscal year ended May 31, 1981, plaintiffs followed the requirements on reductions in interest expense and exclusions from net equity capital, notwithstanding their position that the requirements were mutually exclusive. Each individual cost report identified the interest expense incurred by that plaintiff. Pursuant to the Medicare regulations and instructions, the Hillhaven Corporation, by adjustment to the home office cost report, reduced allowable home office costs by the amount of the interest income from the invested funds. This reduction in cost contained in the home office cost report was reflected in the share of home office costs allocated to

The reporting technique used by plaintiffs is in accord with the Secretary's regulations and instructions governing the filing of cost reports. Section 2150.3 of the Provider Reimbursement Manual (HIM-15) requires the home office of a provider chain to submit a cost report identifying its total operating costs. This report "*must* delete all costs which are not allowable in accordance with program instructions." *Id.* Although plaintiffs believed that the rules limiting the amount reimbursable for return on equity capital were inconsistent, a claim for full reimbursement would have violated the regulations.

C

The Secretary does not contest the fact that plaintiffs reported the disputed costs in the fiscal 1981 cost reports. She does, however, contend that this Court should ignore the evidence of what was in the cost report, which was presented by plaintiffs to the Court in litigation affidavits. Instead, the Secretary would have the Court confine its review to the Administrative Record, which purports to contain those documents before the Board and generated by the Board when it declined to review plaintiffs' claims. The Administrative Record as filed with the Court does not contain plaintiffs' fiscal 1981 cost report.

Defendant in taking this position relies on *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 91 S.Ct. 814, 28 L.Ed.2d 136 (1971). That case holds that a court

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each plaintiff on its cost report. Further, each individual cost report identified that plaintiff's net equity capital. Pursuant to the Medicare instructions, the Hillhaven, by adjustment on the home office cost report, reduced allowable home office equity capital contained by the amount of invested funds. This reduction in equity capital contained in the home office cost report was reflected in the share of home office equity allocated to each plaintiff."

Affidavit of R. L. Kearney, ¶ 8.

reviewing an administrative decision must review the whole record upon which the agency's decision was based. *Id.* at 419-20, 91 S.Ct. at 825. That decision does *not* hold that the Court may consider only the agency record.

> "[S]ince the bare record may not disclose the factors that were considered or the Secretary's construction of the evidence it may be necessary for the District Court to require some explanation in order to determine if the Secretary was acting within the scope of his authority * * *."

Id. at 420, 91 S.Ct. at 825. Although the administrative record does not contain the cost report, this Court cannot determine whether the Board "acted within the scope of [its] authority" without considering the affidavits containing pertinent sections of that report. The Court, therefore, finds it appropriate and necessary to consider plaintiffs' 1981 cost report in order to determine whether the Board erred in refusing jurisdiction over plaintiffs' claims.[3]

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[3] Assuming that the Board denied jurisdiction because the record before it was incomplete, the Court points out that it was the Board's duty to request such information as would allow it to determine its own juridiction. The Provider Reimbursement Review Board Manual provides that:

> "Where the hearing request does not provide sufficient information with respect to the identification of issues, the amount in controversy, etc., the provider *will* be given an opportunity to perfect the appeal. The Board *will* advise the provider in writing of the deficiencies and allow 30 days from the date of such letter to respond with the appropriate information."

PRRB Hearing Manual § 1100.2. Instead of complying with its own mandatory rules, the Board *sua sponte* dismissed the appeal for lack of jurisdiction. *See* Administrative Record at 5. If the Board was in doubt as to whether the items for which review was sought were covered by the cost report, the proper response would have been a request for the providers to submit the relevant cost report. *See Alexandria Hospital v. Heckler*, 586 F.Supp. 581 (E.D.Va.1984) (remanding action to Board to take more evidence on the question whether disputed costs were covered by the cost reports).

D

The central disagreement between the parties remains to be addressed: Does the jurisdiction of the Board depend on plaintiffs' having actually claimed reimbursement, or is it enough that they recorded the total cost of equity capital ~~and then~~ self-disallowed certain amounts as required by the disputed regulations? The Secretary contends, despite her own regulations discussed above, that plaintiffs should have claimed the full amount for reimbursement. This interpretation of 42 U.S.C. § 1395oo(d) unacceptably strains the language of the statute and has been rejected by those courts that have considered the question.

The statute conferring jurisdiction on the Board to review the fiscal intermediary's reimbursement decisions is clear on its face. The Board may review "matters *covered* by such cost report * * * * even though such matters were *not considered* by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d) (emphasis added). The statute does not require that the provider *claim* the disputed amount, only that it be "covered" by the report. Indeed, claiming an item for reimbursement in contravention of a regulation disallowing that item may subject the provider to charges of fraud.[4] The conclusion that an

[4] The impossible position providers are put in by the Secretary's understanding of the procedures necessary to obtain Board jurisdiction is demonstrated by *Our Lady of Lourdes Memorial Hospital v. Schweiker*, No. 80-CV-226 (N.D.N.Y., July 26, 1982), CCH Medicare and Medicaid Guide ¶ 32,154. After regulations governing reimbursement for physician emergency standby fees were changed, the provider continued to claim reimbursement and objected to the new regulations. The provider was warned by the intermediary that if it continued to claim reimbursement under the former system it would be subject to fraud charges pursuant to 42 U.S.C. § 1395nn. At the end of the next fiscal year the provider recorded the emergency room standby costs, but self-disallowed them in accordance with the intermediary's instructions. Shortly thereafter, the regulations were

item need not be claimed is buttressed by the last clause of the section, which explicitly allows the Board to review matters not considered by the intermediary.

In a case on all fours with this litigation the Seventh Circuit defined the scope of Board jurisdiction. *St Mary of Nazareth Hospital v. Department of Health and Human Services,* 698 F.2d 1337 (7th Cir.), *cert. denied* ____ U.S. ____, 104 S.Ct. 107, 78 L.Ed.2d 110 (1983). *St. Mary of Nazareth* was a consolidated appeal of two district court cases, *St. Mary of Nazareth*, 531 F.Supp. 419 (N.D.Ill.1982), and *St. James Hospital v. Harris*, 535 F.Supp. 751 (N.D.Ill.1981). The question of Board jurisdiction was raised in the appeal from the lower court's decision in *St. James Hospital.*

During the 1977 fiscal year, St. James Hospital installed bedside telephones for all its patients including those on Medicare.

> "In their annual report to the fiscal intermediary and in order to comply with the Secretary's regulations St. James entered the cost of this 'personal comfort item'[5] on worksheet A-8 of the 1977 Medicare Costs Report. The effect of this worksheet (A-8) entry acted as a 'self-disallowance' of the overall patient tele-

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again changed, reverting to the former means of reimbursing emergency room costs. The provider then asked the Board to review its reimbursements, pursuant to the new regulations. The Board refused, stating that it had no jurisdiction because the costs were not "claimed" in the cost report. The District Court reversed, finding that because the self-disallowance was recorded in the cost report, the item was "covered" therein and so reviewable pursuant to 42 U.S.C. § 1395oo(d).

[5] "Personal comfort items" are not reimbursable. *See* 42 U.S.C. § 1395y(a)(6). The provider in *St. James* argued unsuccessfully that bedside telephones provided therapeutic benefits and were incorrectly categorized by the Secretary as a "personal comfort item."

> phone costs ($17,000) and thus the question of the telephone costs was not presented to the fiscal intermediary for review."

Id. at 1340-41. The hospital recognized that telephone costs had been found by the Secretary to be a nonreimbursable "personal comfort item" and so self-disallowed the expense on the cost report, just as plaintiffs did in this case.

Also as in the case at bar, the Board refused to review St. James Hospital's claim because the hospital had itself disallowed the telephone costs, the Secretary taking the position that the statute required that a claim for reimbursement be made to the intermediary as a prerequisite to Board jurisdiction. *Id.* at 1346. The circuit rejected the Secretary's restrictive reading of § 1395oo(d):

> "This section vests broad authority in the Provider Reimbursement Review Board to review the finding of the fiscal intermediary and make any adjustment to the cost reports the Board deems necessary. As the statute itself expressly states, the Board may consider any matter 'even though such matters were not considered by the intermediary in making such final determination."

Id. at 1346. The court then held that the Board had jurisdiction to review St. James Hospital's claims, because the self-disallowance procedure resulted in the claims being covered in the cost report. *Accord Our Lady of Lourdes Memorial Hospital, supra.*[6]

Similar reasoning was followed in *Athens Community Hospital, supra*, 686 F.2d 989 (D.C.Cir.1982). The court noted that by recording a "self-disallowance" in the cost report, the provider gives the intermediary an opportunity to decide that reimbursement is proper and notifies the

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[6] See discussion of *Our Lady of Lourdes Memorial Hospital,* at note 4, *supra.*

Medicare system that the costs exist and may be claimed in the future. The fact of the self-disallowance is "analogous to a disallowance by the intermediary of costs claimed in the initial cost report. Review of self-disallowance claims in the context of an existing appeal is therefore not at all the same as the review of claims for costs not disclosed in the initial cost report * * *." *Id.* at 997.[7]

The Secretary argues that *St. James* and *Our Lady of Lourdes* are not on point because in those cases the providers had in some manner brought the disputed items to the fiscal intermediaries' attention, in addition to self-disallowing the costs. Because "there was a history of conflict on the disputed costs between the provider and the intermediary," the Secretary contends that those decisions should be distinguished from the case at bar. See Def.Opp. to Plf. Motion for Reconsideration, at 5-6. Although the district court's decision in *St. James* mentioned that conflict, (535 F.Supp. at 755), the appellate court did not, (698 F.2d at 1340-41); neither court held or even intimated that Board jurisdiction required anything more than recording the disallowance in the cost report. Similarly, the district court in *Our Lady of Lourdes* reported the history of the provider's dispute with the intermediary over emergency room costs (*see* note 4, *supra*), but did not suggest that Board jurisdiction turned on the existence of that dispute.

Although this Court is not bound by *St. James* or *Our Lady of Lourdes*, the reasoning in those decisions is persuasive. The statute makes no further demands on a pro-

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[7] In *Athens Community Hospital v. Schweiker*, 686 F.2d 989 (D.C.Cir.1982), the court found that the Board did not have jurisdiction over a provider's claim, where the provider had entirely omitted any mention of the item for which it later sought Board review. The court distinguished *St. James* because that hospital had made self-disallowances, and commented that that factual distinction was "sufficient to eliminate [*St. James*] as precedential support for appellees." *Id.* at 997.

vider beyond including the costs in the report. If the provider did not make an appropriate disallowance, it would clearly be out of compliance with the regulations. Thus, to follow the Secretary's interpretation of the statute, the provider would have to choose between claiming a nonreimbursable expense and risking possible fraud charges, or losing the right to challenge the disallowance before the Board. Such a result is clearly not what Congress intended. The Court, therefore, holds that an item is "covered by" the cost report within the meaning of 42 U.S.C. § 1395oo(d) if a "self-disallowance" of the cost is reported in the cost report, and that the Board has jurisdiction to review disputes regarding such disallowed costs.

Accordingly,

IT IS HEREBY ORDERED THAT

(1) Plaintiffs' motion for summary judgment is granted; and

(2) The Board shall accept jurisdiction over plaintiffs' request that their fiscal 1981 cost reports be reviewed with respect to the application of the regulations governing reimbursement of reasonable return on equity capital pursuant to 42 C.F.R. § 405.429(a).

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

CIVIL CASE No. C85 3370 WHO

THE BOARD OF TRUSTEES OF THE LELAND STANFORD JUNIOR UNIVERSITY, STANFORD UNIVERSITY HOSPITAL, PLAINTIFFS

vs.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

[Filed: Jan. 29, 1986]

ORDER

The cross motions of plaintiffs and defendants for summary judgment having been considered by this Court on January 15, 1986, all parties having had an opportunity to present argument on said motions, there existing no genuine issue as to any material fact, and plaintiffs being entitled to a judgment as a matter of law, it is hereby ordered that:

1. Plaintiffs' motion for summary judgment is granted based on this Court's decision in *Adams House Health Care v. Margaret M. Heckler, Secretary of HHS*, 604 F. Supp. 110 (N.D. Cal. 1984).

2. Defendants' motion for summary judgment is denied.

3. This matter is remanded to the Secretary of Health and Human Services for review of the merits of plaintiffs' claims by the Provider Reimbursement Review Board.

4. All parties are to bear their own costs.
Dated: January 29, 1986.

/s/ ALFONSO J. ZIRPOLI
Judge
United States District Court

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 85-1512
DC CV 83-3020

ADAMS HOUSE HEALTH CARE, ADRIAN-HILLHAVEN CONVALESCENT CENTER; ALTA VISTA HEALTHCARE; ALVARADO CONVALESCENT AND REHABILITATION HOSPITAL; ET AL., PLAINTIFFS-APPELLEES

v.

MARGARET M. HECKLER, ETC., DEFENDANT-APPELLANT

No. 86-1872
DC CV 85-3370 WHO

BOARD OF TRUSTEES OF THE LELAND STANFORD JUNIOR UNIVERSITY; STANFORD UNIVERSITY HOSPITAL, PLAINTIFFS-APPELLEES

v.

OTIS R. BOWEN, ETC., DEFENDANT-APPELLANT

[Filed: June 11, 1987]

JUDGMENT

APPEAL from the United States District Court for the Northern District of California.

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Northern District of California and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this Cause be, and hereby is affirmed.

Filed and entered May 18, 1987

APPENDIX E

DEPARTMENT OF HEALTH AND
HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21207

Refer to
JBR:83-63G

Location: Professional Bldg
Room 104
301-594-6172

APR. 19, 1983

Certified Mail

Eugene Tillman, Esquire
Pierson, Ball and Dowd
100 Ring Building
1200 18th Street, N.W.
Washington, D.C. 20036

Dear Mr. Tillman:

Re: Hillhaven, Inc., Group Appeal, Tacoma, Washington, Provider Nos.—(See enclosure 1), Case No. 83-63G, F/Y/E—May 31, 1981

A review of the hearing request in the above-captioned case reveals that the two issues in dispute involve self-disallowances by the Providers. The request states:

> ". . . In preparing its home office cost statement and the facilities' cost reports, Hillhaven followed the Medicare instructions contained in HIM 15 by excluding the invested funds from the equity capital computation (HIM 15, section 1218.2) and by off-

> setting the interest income on the invested funds against allowable interest expense (HIM 15, section 202.2)." ". . . compliance with these instructions has resulted in self-disallowances. . . ." "Notwithstanding the submission of amended cost reports, the Intermediaries issued Notices of Program Reimbursement which failed to recognize the claim. . . ."

The request further states the Board should accept jurisdiction of these issues based upon the *St. James v. Harris,* Civil Action No. 80-C-735 (N.D. Ill., Dec. 4, 1981), and the controlling case of *Athens Community Hospital, Inc., v. Schweiker,* 514 F Supp. 1336 (D.D.C. 1981). The Board agrees that the *Athens* case is controlling, but the Board points out that the cited District Court case was reversed on appeal with a very strong opinion; and this Circuit Court case (see p. 3 of enclosure II) is relied upon by this Board in finding that there is no jurisdictional authority concerning the two issues in this particular case. The Board also does not find the *St. James* case, supra, factually the same nor persuasive particularly in the light of the Circuit Court decision in *Athens* which held a particular cost must be claimed for it to be an appealable issue. Further, the Court stated that permitting de novo claims before the Board would deprive the Intermediary's analysis and conclusions thereby making the Board a tribunal of original jurisdiction and eliminating a tier of review. This would be contrary to the statutory and regulatory design meticulously worked out by the Congress and the Secretary.

The Board's finding that it does not have jurisdictional authority concerning the two disputed matters is based upon the fact that the costs were not claimed in the various Providers' cost reports; nor have any amended cost reports been accepted by the Intermediary on this issue; nor have

any Notices of Program Reimbursement (NPR's) included any denials or adjustments of cost(s) pertaining to the subject issue.

The Providers submitted a request to their Intermediary (Aetna) on March 26, 1982, seeking permission to file an amended cost report for a reopening of the cost reports and the Notices of Program Reimbursement issued in February 1982 in order to preserve appeal rights in view of a Board decision on the disputed issue. The Intermediary denied the request because the proposed changes did not properly reflect Medicare cost reporting requirements and were not acceptable to the Health Care Financing Administration (HCFA). Under the provisions of 42 CFR 405.1885(c), the Intermediary has exclusive jurisdiction of this reopening.

It is significant that the Providers did not initially contest or place the Intermediary on notice of any disagreement concerning these issues at the time the cost report was filed. The Providers are required to claim a cost in a filed cost report or, at least, disclose its position on the issue so the Intermediary can make a final determination. In this case, the Providers indicated the cost report was filed according to the Medicare manual instructions under the belief the particular costs in question were impermissable; and that it did not consider contesting these items until after a favorable Board decision on the subject. At that time, the Providers correctly made an attempt to preserve appeal rights by seeking permission to amend its cost report which was ultimately denied. Further, there is no indication that there was a series of letters exchanged between the Providers and Intermediary causing the disputed matters to be deleted from the initial cost report (as found in the *St. James* case).

Accordingly, for the foregoing reasons and those contained in enclosure II, the Board cannot accept the hearing request. This determination is subject to the provisions of 42 U.S.C. 1395oo(f).

It is noted that six Providers included in the group (designated by an * in the column entitled "Date of NPR" in the attachment to the request - see enclosure I) had not received an NPR. In such situations, these Providers are only entitled to a hearing under the provisions of 42 U.S.C. 1395oo(a)(1)(B), i.e., non-issuance of an NPR on a timely basis. Accordingly, the type of hearing involved for that purpose is the ultimate issuance of an NPR; and there are no substantitive issues to appeal until an NPR is issued. We assume there was a misunderstanding concerning the types of hearings and that these Providers were inappropriately included in the request for hearing on the merits of the substantitive issues. Thus, it was premature to include these Providers as part of this group.

Board Members Participating:

Thomas M. Tierney
Bette A. Kraus
Paul Morton Ganeles, CPA
Richard A. Dudgeon, CPA

FOR THE BOARD:

Thomas M. Tierney
Chairman

1 Enclosures
Schedule of Providers
Denial of Jurisdiction

cc:
Irwin Cohen, Esquire, Attorney Advisor, HCFA
Mr. Josh Basson, Aetna Life & Casualty

APPENDIX F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
6660 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21207

Refer to
BJD:83-1040

Location: Professional Bldg
Room 104

MAR. 19, 1985

Mr. Michael P. Fossier
Associate Counsel for Medical Affairs
Stanford University
P.O. Box N
Stanford, CA 94305

Re: Stanford University, Stanford, CA, Provider No. 05-0441, Case No. 83-1040, F/Y/E – August 31, 1981

Based on documentation provided by you in connection with your request for hearing dated September 20, 1983, which was assigned case number 83-1040, we find that our jurisdiction does not extend to your dispute of labor delivery room days and data processing costs.

Under Section 1978, Title XVIII, Social Security Act, as amended, and 42 CFR 405.1835, a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary (NPR) and the amount in controversy is $10,000, or more, and the request for hearing was filed within 180 days of the date of the NPR.

In your case, the cost in dispute was not claimed on the filed cost report for labor delivery room days nor was there an audit adjustment for data processing costs.

This statutory requirement is a prerequisite to a provider's right to a hearing. Failure to fulfill it results in the Board having no jurisdiction to conduct a hearing with respect to these two issues.

Board Members Participating:

Paul Morton Ganeles
Barbara J. Sinnott
Edward A. Hofler
Thomas F. Clinton, Jr.
Arthur P. Owens

FOR THE BOARD:

Barbara J. Sinnott
Board Member

APPENDIX G

42 U.S.C. (& Supp. III) 1395*oo* provides in pertinent part:

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if –

(1) such provider –

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A) or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

* * * * *

(d) Decisions of Board

A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

* * * * *

(f) Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the

provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District

Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5 notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) of this section must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

* * * * *

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Supreme Court, U.S.
FILED
DEC 4 1987
JOSEPH F. SPANIOL, JR.
CLERK

No. 87-443

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

OTIS R. BOWEN, SECRETARY OF
HEALTH AND HUMAN SERVICES,
Petitioner,

v.

ADAMS HOUSE HEALTH CARE, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

BRIEF IN OPPOSITION

EUGENE TILLMAN *
ROBERT J. AAMOTH
PIERSON, BALL & DOWD
1200 18th Street, N.W.
Washington, D.C. 20036
(202) 331-8566
Attorneys for Respondents In Docket No. 85-1512 Below

* Counsel of Record

December 5, 1987

TABLE OF CONTENTS

	Page
ARGUMENT	2
I. THIS CASE DOES NOT POSE AN ISSUE OF SUFFICIENT IMPORTANCE TO JUSTIFY GRANTING THE SECRETARY'S PETITION	2
A. Providers Have Generally Discontinued The Practice Of Raising Reimbursement Disputes First With The PRRB	2
B. The Underlying Reimbursement Scheme Has Now Been Largely Superseded By The Prospective Payment System	6
C. The Legal Issue At Stake Has No Broader Application Beyond Cases Involving Section 1395oo(d)	7
II. THE NINTH CIRCUIT CORRECTLY INTERPRETED SECTION 1395oo(d) TO PERMIT DISPUTES OVER SELF-DISALLOWED COSTS TO BE RAISED FIRST WITH THE PRRB	7
CONCLUSION	10

TABLE OF AUTHORITIES

Cases: Page

Adams House Health Care v. Heckler, 817 F.2d 587 (9th Cir. 1987) ---------- *passim*
Alexandria Hospital v. Heckler, 660 F. Supp. 23 (E.D. Va. 1985) ---------- 5
Athens Community Hospital, Inc. v. Schweiker, 686 F.2d 989 (1982), *modified*, 743 F.2d 1 (D.C. Cir. 1984) ---------- 3, 5
Baptist Hospital East v. Secretary, 802 F.2d 860 (6th Cir. 1986) ---------- 5
Bethesda Hospital v. Secretary, 810 F.2d 558 (6th Cir. 1987), *cert. granted*, No. 86-1764 ---------- *passim*
Community Hospital of Roanoke Valley v. Department, 770 F.2d 1257 (4th Cir. 1985) ---------- 5
Heckler v. Community Health Services of Crawford Cour'ty, Inc., 467 U.S. 51 (1984) ---------- 9
North Broward Hospital District v. Bowen, 808 F.2d 1405 (11th Cir. 1987) ---------- 5
Our Lady of Lourdes Memorial Hospital v. Schweiker, No. 80-CV-226 (N.D.N.Y. July 26, 1982) ---------- 5
Saline Community Hospital Association v. Secretary, 744 F.2d 517 (6th Cir. 1984) ---------- 5
St. Luke's Hospital v. Secretary, 810 F.2d 325 (1st Cir. 1987) ---------- 5
St. Mary of Nazareth Hospital Center v. Department, 698 F.2d 1337 (7th Cir. 1983) ---------- 5
Tallahassee Memorial Regional Medical Center v. Bowen, 815 F.2d 1435 (11th Cir. 1987) ---------- 5
University of Cincinnati v. Secretary, 809 F.2d 307 (6th Cir. 1987) ---------- 5
University of Michigan Hospitals v. Heckler, 609 F. Supp. 756 (E.D. Mich. 1985) ---------- 5

Statutes:

42 U.S.C. § 1395h ---------- 9
42 U.S.C. § 1395x(v)(1)(A) ---------- 6
42 U.S.C. § 1395oo(d) ---------- *passim*

TABLE OF AUTHORITIES—Continued

Page

Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-607, 97 Stat. 65, 149 (1983) 6
Social Security Amendments of 1972, Pub. L. No. 92-603, § 243, 86 Stat. 1329 (1972)..... 3

Legislative Materials:

S. Rep. No. 92-1230, 92d Cong., 2d Sess. 248-49 (1972) 3

Agency Rules & Actions:

42 C.F.R. § 405.1801(a)(1)..... 8
PRRB Hearing Dec. Nos. 83-D76 & 84-D17, 1984-1 Transfer Binder, Medicare & Medicaid Guide (CCH), ¶¶ 33,461 & 33,599 (Apr. 20, 1983 and Jan. 10, 1984)..... 5

IN THE

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OTIS R. BOWEN, SECRETARY OF
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ADAMS HOUSE HEALTH CARE, *et al.*,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

BRIEF IN OPPOSITION

The respondents [1] respectfully submit that the petition for a writ of certiorari to the United States Court of Appeals for the Ninth Circuit, filed by the Solicitor General

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[1] The judgment of the United States Court of Appeals for the Ninth Circuit involved two cases which were consolidated at oral argument, Nos. 85-1512 and 86-1872. The instant brief is filed solely on behalf of the respondents which were appellees in No. 85-1512. Those respondents are wholly owned by the Hillhaven Corporation, which is a wholly-owned subsidiary of National Medical Enterprises, Inc.

on behalf of the Secretary of Health and Human Services ("Secretary"), should be denied.[2]

ARGUMENT

I. THIS CASE DOES NOT POSE AN ISSUE OF SUFFICIENT IMPORTANCE TO JUSTIFY GRANTING THE SECRETARY'S PETITION

There are no "special and important reasons" which support the grant of a writ of certiorari in this case. Supreme Court Rule 17.1. The only question of law involves a particular cost reporting practice by some Medicare providers which has largely been abandoned since 1981. Further, that question of law arises from a statutory reimbursement scheme which for most providers has been superseded by the wholly new prospective payment system which Congress mandated in 1983. As a result, the legal issue in the instant case is little more than an historic relic of merely academic interest which does not merit review by this Court.

A. Providers Have Generally Discontinued The Practice Of Raising Reimbursement Disputes First With The PRRB

The instant case is one of several so-called "self-disallowance" cases. *See infra* note 6. "Self-disallowance" occurs when a health care provider seeking reimbursement under the Medicare program submits a cost report to the Secretary's fiscal intermediary and, on the cost report, lists and then deducts certain costs which are specifically disallowed under the Secretary's rules and policies. In the past, when a provider believed that the rule

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[2] We note that the Court has granted a writ of certiorari in No. 86-1764, *Bethesda Hospital Ass'n v. Bowen*, which involves the same legal issue as the instant case. To the extent the Court wishes to treat the two cases similarly, we submit that the Court should deny the petition in the instant case and dismiss the writ of certiorari as improvidently granted in *Bethesda Hospital*.

or policy requiring a particular self-disallowance was unlawful under the Social Security Act, the provider typically would challenge the disputed rule or policy in the first instance before the Provider Reimbursement Review Board ("PRRB").[3] This practice was fairly widespread in the 1970's and, to a lesser extent, in the very early 1980's.

Although the PRRB at the start did not question its jurisdiction where the provider had complied with the challenged rule or policy by effecting the required self-disallowance, it began declining to review such matters in the late 1970's. Those decisions implemented the Secretary's revised interpretation of 42 U.S.C. § 1395oo(d) to require disputes over self-disallowed costs to be presented initially to the fiscal intermediary, even though the intermediary is a private contractor with no authority to set aside or disregard the Secretary's rules and policies.[4] Although that interpretation was brand new and contravened existing practice at the time, the agency never issued a formal statement of its position. Instead, the Secretary's interpretation of Section 1395oo(d) was disseminated to the industry slowly and haphazardly over a period of several years through the medium of PRRB decisions.[5]

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[3] Congress created the PRRB to give providers a means of obtaining administrative review over their Medicare reimbursement disputes. Social Security Amendments of 1972, Pub. L. No. 92-603, § 243, 86 Stat. 1328 (1972); *see also* S. Rep. No. 92-1230, 92d Cong., 2d Sess. 248-49 (1972).

[4] This hypertechnical view of the PRRB's jurisdiction (*see infra* pp. 7-10) had the anomalous effect of penalizing providers which filed cost reports in compliance with the Secretary's rules and policies.

[5] *See generally* Athens Community Hosp., Inc. v. Schweiker, 686 F.2d 989, 996 (D.C. Cir. 1982) (recognizing earlier PRRB decisions which considered disputes over self-disallowed costs which had not been presented to the fiscal intermediary).

Once Medicare providers and their counsel became aware of the various PRRB decisions, and learned that those decisions reflected the Secretary's new interpretation of the Medicare statute, they generally discontinued the practice of raising reimbursement disputes with the PRRB in the first instance. However much the providers disagreed with the Secretary's statutory interpretation, it simply was not worth the candle to adhere to contrary prior practice. Once understood, the Secretary's position was relatively easy to comply with, and lengthy, expensive and needless litigation awaited any provider who followed the prior practice.

The Secretary's actions in this case and others like it made clear that all disputes over Section 1395oo(d) would be litigated to the maximum degree permitted by law. Here, the providers' claim for approximately $52,000 has now been litigated through two lower federal courts all the way to this Court on the question of the PRRB's jurisdiction, while the providers' dispute on the merits remains the subject of separate litigation, recently stayed. in the United States District Court for the District of Columbia. Rather than run such a gauntlet, providers have generally found it far easier just to change their cost reporting practices to bring reimbursement disputes initially before the fiscal intermediary even though the intermediary lacks authority to resolve the disputes or grant the relief requested. That has been the prevailing practice since 1981.

The result is that most lawsuits in federal courts on the Secretary's interpretation of Section 1395oo(d) involved cost reports which were filed during the relatively brief period of time from the PRRB's first adherence to the Secretary's interpretation of Section 1395oo(d) in the late 1970's, to the early 1980's when news of that interpretation finally reached all segments of the industry. *Of all the published federal court decisions on this issue to date, not one involves a cost report filed later than the*

1981 fiscal year.[6] The "self-disallowance" cases appear to have been a one-time phenomenon, the by-product of a now-completed transition period to the Secretary's new regulatory regime under Section 1395oo(d) in which reimbursement disputes over self-disallowed costs are raised initially before the fiscal intermediary, not the PRRB.[7] This Court should not grant a writ of certiorari

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[6] Of the decisions which contain some statement of the fiscal year (FY) for which the cost reports were filed, see (i) *Adams House Health Care v. Heckler*, 817 F.2d 587, 589, 590 (9th Cir. 1987) (two consolidated cases involving FY 1981); (ii) *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435, 1442 n.9 (11th Cir. 1987) (FY 1980 & 1981); (iii) *Bethesda Hosp. v. Secretary*, 810 F.2d 558, 560 (6th Cir. 1987) (FY 1980 & 1981); (iv) *St. Luke's Hosp. v. Secretary*, 810 F.2d 325, 327 (1st Cir. 1987) (FY 1978 & 1979); (v) *University of Cincinnati v. Secretary*, 809 F.2d 307, 308 (6th Cir. 1987) (FY 1979, 1980 & 1981); (vi) *North Broward Hosp. Dist. v. Bowen*, 808 F.2d 1405, 1407 (11th Cir. 1987) (FY 1977); (vii) *Baptist Hosp. East v. Secretary*, 802 F.2d 860, 862 (6th Cir. 1986) (FY 1981); (viii) *Saline Community Hosp. Ass'n v. Secretary*, 744 F.2d 517, 518 (6th Cir. 1984) (per curiam) (FY 1979); (ix) *St. Mary of Nazareth Hosp. Center v. Department*, 698 F.2d 1337, 1339 (7th Cir. 1983) (FY 1977 & 1978); (x) *Athens Community Hosp., Inc. v. Schweiker*, 686 F.2d 989, 991 (1982), *modified*, 743 F.2d 1, 4 (D.C. Cir. 1984) (FY 1973 & 1974); (xi) *Alexandria Hosp. v. Heckler*, 660 F. Supp. 23, 24 (E.D. Va. 1985) (FY 1980); and (xii) *Our Lady of Lourdes Memorial Hosp. v. Schweiker*, No. 80-CV-226 (N.D.N.Y. July 26, 1982) (FY 1977). Although the decisions in *Community Hosp. of Roanoke Valley v. Department*, 770 F.2d 1257 (4th Cir. 1985), and *University of Michigan Hosp. v. Heckler*, 609 F. Supp. 756 (E.D. Mich. 1985), do not appear to indicate when the relevant cost reports were filed, the PRRB decisions which gave rise to those cases indicate that the cost reports were filed for FY 1977 through 1980 in the *University of Michigan* case and for FY 1977 through 1981 for the *Roanoke Valley* cases. *See* PRRB Hearing Dec. Nos. 83-D76 & 84-D17, 1984-1 Transfer Binder, Medicare & Medicaid Guide (CCH), ¶¶ 33,461 & 33,599 (Apr. 20, 1983 and Jan. 10, 1984).

[7] The Secretary claimed in his brief acquiescing to certiorari in *Bethesda Hospital* that "many disputes" involving the old reimbursement scheme are still pending. Brief for the Respondent at

to resolve a legal issue with no continuing significance to Medicare providers or the Secretary.

B. The Underlying Reimbursement Scheme Has Now Been Largely Superseded By The Prospective Payment System

The issue of whether disputes over self-disallowed costs may be raised initially with the PRRB applies only to Medicare providers which receive reimbursement on a "reasonable cost" basis. In general, providers reimbursed on that basis are paid retrospectively, based upon the providers' actual costs in furnishing services. While the respondents, as skilled nursing facilities, continue to receive reimbursement on that basis (*see* 42 U.S.C. § 1395x (v)(1)(A)), Congress in 1983 adopted a wholly new prospective payment system for most hospitals to replace the "reasonable cost" method of reimbursement. Under the new system, these hospitals are paid prospectively, based upon the "diagnosis-related group" into which individual patients fall. Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-607, 97 Stat. 65, 149 (1983).[8]

Although the Secretary correctly points out in *Bethesda Hospital* that a few types of health care providers and categories of costs are still governed by the "reasonable cost" system (Brief for the Respondent at 13-14), the Secretary has ignored the fact that for the substantial majority of Medicare providers who are now reimbursed under the prospective payment system, the legal issue in

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14 n.12. The Secretary carefully stopped short, however, of representing that those disputes involved the legal issue at stake here, namely, whether the PRRB has jurisdiction to review reimbursement disputes not presented intially to the fiscal intermediary.

[8] The Secretary acknowledged this in his brief on the petition for a writ of certiorari in *Bethesda Hospital*. *See* Brief for the Respondent at 13.

this case is largely irrelevant.[9] Coupled with the dramatic change in self-disallowance practices since 1981, the adoption of the prospective payment system by Congress in 1983 obviates Supreme Court review of the issue at hand.

C. The Legal Issue At Stake Has No Broader Application Beyond Cases Involving Section 1395oo(d)

There are no other reasons to grant a writ of certiorari in this case. The disputed legal issue is critically dependent upon the actual words of the statute, and we are unaware of any similarly-worded statutory provision which would benefit from a decision on the merits. Such a decision would be relevant only to those few cases where providers raised reimbursement disputes over self-disallowed costs in the first instance with the PRRB under the old statutory reimbursement scheme. We do not believe an issue of such limited importance warrants review by this Court.

II. THE NINTH CIRCUIT CORRECTLY INTERPRETED SECTION 1395oo(d) TO PERMIT DISPUTES OVER SELF-DISALLOWED COSTS TO BE RAISED FIRST WITH THE PRRB

Section 1395oo(d) contains two broad grants of jurisdiction to the PRRB. Each grant, by its terms, gives the PRRB authority to hear disputes regarding the lawfulness of the Secretary's reimbursement rules and policies which were not raised initially with the fiscal intermediary.

The first grant provides that the PRRB "shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report . . . ." It is not disputed that providers which

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[9] It is significant to note that with the exception of the instant case, all of the reported self-disallowance cases (*see supra* note 6) have involved hospitals.

self-disallow costs and then challenge the underlying rule or policy before the PRRB are seeking to "modify" a final determination of the fiscal intermediary.[10] Because the self-disallowed costs are included on the cost report, and because reimbursement for such costs would modify the total reimbursement awarded for that cost report, the relief sought is patently "with respect to a cost report." By itself, this provision gives the PRRB jurisdiction to hear and decide reimbursement disputes over self-disallowed costs in the first instance.

If there were any doubt as to the PRRB's jurisdiction under the first grant (and we believe there should be none), the second grant provides unambiguously that the PRRB shall have power "to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary in making such final determination*" (emphasis supplied). This grant makes clear that Congress intended to authorize the PRRB to decide issues involving self-disallowed costs which had not been presented to the fiscal intermediary. Operating in tandem, these two jurisdictional grants underscore the PRRB's plenary jurisdiction under Section 1395oo(d) to hear all reimbursement disputes involving cost reports regardless of whether such disputes were first presented to or considered by the fiscal intermediary.

The Secretary's contrary position betrays not only the plain words of the statute, but common sense as well. The fiscal intermediary is no more than a private in-

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[10] The Secretary has defined a final determination as the intermediary's "determination of the amount of total reimbursement due the provider." 42 C.F.R. § 405.1801(a)(1). Thus, the "final determination" referenced in Section 1395oo(d) is simply a number, *i.e.*, the amount of Medicare reimbursement which the intermediary finds is due the provider under the Secretary's rules and policies.

surance company which the Secretary hires to audit cost reports (42 U.S.C. § 1395h); it is not a legal tribunal, nor does it resolve legal disputes or possess legal expertise. As the Ninth Circuit correctly noted, the intermediary lacks any authority whatsoever to resolve challenges to the lawfulness of the Secretary's rules and policies. *Adams House Health Care*, 817 F.2d at 592.[11]

The Secretary argued before the Ninth Circuit that legal issues should nevertheless be presentd to the fiscal intermediary when the cost report is filed so that the PRRB may benefit from the intermediary's views on the issue. Reply Brief for Appellant at 13. Such a procedure is unnecessary, however, because the fiscal intermediary actually participates in the PRRB proceeding as a party by filing a brief on the merits, as it did in this case. The Secretary's argument that raising reimbursement disputes for the first time before the PRRB causes practical difficulties is equally meritless. *See id.*, 817 F.2d at 592-93.

The Secretary's proposed interpretation would make a relatively straightforward provision complex for no apparent purpose other than to frustrate, through hypertechnical interpretation, the efforts of providers to obtain review of *bona fide* reimbursement disputes. When compared to the statutory language, it is clear that the whole of the Secretary's interpretation is less than the sum of its statutory parts. The Secretary would construe two broadly-worded statutory provisions—each of which by itself is drafted broadly enough to grant the PRRB jurisdiction to hear reimbursement disputes in the first instance—in such a way that neither supports PRRB juris-

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[11] The Secretary conceded this point before the Ninth Circuit. *See* Brief for Appellant at 30. *Cf.* Heckler v. Community Health Services of Crawford County, Inc., 467 U.S. 51 (1984) (holding that the Secretary of Health and Human Services is not estopped from enforcing the agency's rules and policies by the contrary position of the fiscal intermediary).

diction over such disputes. That interpretation is presumptively unreasonable, and the Ninth Circuit correctly rejected such an interpretation in favor of one which comports with the evident Congressional design to give the PRRB plenary jurisdiction over reimbursement disputes involving cost reports.

CONCLUSION

For the foregoing reasons, the respondents submit that the petition for a writ of certiorari should be denied.

Respectfully submitted,

EUGENE TILLMAN *
ROBERT J. AAMOTH
PIERSON, BALL & DOWD
1200 18th Street, N.W.
Washington, D.C. 20036
(202) 331-8566
Attorneys for Respondents
In Docket No. 85-1512 Below

* Counsel of Record

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